Health and Dental Benefits Comparison –
Plan Year July 1, 2017 – June 30, 2018
JCC, FR, FO, FL, BOS & COURTHOUSE

Employees hired on or after 7/1/15

Plans	Coverage Type	Total Premium	HSA Employer Contribution	Total Plan Costs	Employer Pays Per Month	Employee Pays Per Month
CONSUMER DRIVEN HEALTH PLAN – with HSA HealthKeepers Point of Service Plan (POS)	Employee Dual Family	$484.00 $1,015.00 $1,420.00	$125.00 $125.00 $125.00	$609.00 $1,140.00 $1,545.00	$565.00 $1,003.00 $1,353.00	$44.00 $137.00 $192.00
CONSUMER DRIVEN HEALTH PLAN – with HSA Optima Point of Service Plan (POS)	Employee Dual Family	$484.00 $1,015.00 $1,420.00	$125.00 $125.00 $125.00	$609.00 $1,140.00 $1,545.00	$565.00 $1,003.00 $1,353.00	$44.00 $137.00 $192.00
Delta Dental PPO Plus Premier Plan 1	Employee Dual Family	$22.00 $41.00 $65.00	Not applicable	$22.00 $41.00 $65.00	$20.00 $36.00 $55.00	$2.00 $5.00 $10.00
DeltaCare DHMO	Employee Dual Family	$27.00 $52.00 $82.00	Not applicable	$27.00 $52.00 $82.00	$21.00 $37.00 $57.00	$6.00 $15.00 $25.00
Delta Dental PPO Plus Premier Plan 2	Employee Dual Family	$33.00 $59.00 $85.00	Not applicable	$33.00 $59.00 $85.00	$21.00 $36.00 $55.00	$12.00 $23.00 $30.00

CONSUMER DRIVEN HEALTH PLANS

AC = Allowable Charge	Anthem HealthKeepers Lumenos HSA 573 (POS – Open Access)	Optima Equity Vantage 3000/100% (POS – Open Access)
Pre-Existing Condition Waiting Period	None	None
Dependent Coverage to the end of Calendar Year	Until age 26	Until age 26
Out of Area Coverage	Emergency & Urgent care; may choose PCP in other location; special program if living out of state	Out of area dependent rider (enrollment required) Emergency & Urgent care only
Out of Network	Covered at 70% [AC] after $3,000/$6,000 deductible and with $6,000/$12,000 out of pocket maximum	Covered at 70% [AC] after $3,000/$6,000 deductible and with $6,000/$12,000 out of network maximum
	In Network	**In Network**
Open Access	No referral needed to see specialist	No referral needed to see specialist
Deductible per Year (combined in and out of network)	$3,000/person $6,000/family	$3,000/person $6,000/family
Out of Pocket Maximum per Year	$4,000/person $8,000/family	$4,000/person $8,000/family
Physician Services		
Preventive Wellness Visits and Well Baby Visits	$0 copay then covered at 100%	$0 copay then covered at 100%
PCP Office Visit	Covered at 100% after deductible	Covered at 100% after deductible
Specialist Office Visit	Covered at 100% after deductible	Covered at 100% after deductible
Spinal Manipulation (Chiropractic Care Services)	Covered at 100% after deductible	Covered at 100% after deductible
Lab, X-ray, Ultrasound and Diagnostic	Covered at 100% after deductible	Covered at 100% after deductible
MRI, MRA, CT, CTA and PET scans – regardless of location	Covered at 100% after deductible	Covered at 100% after deductible

CONSUMER DRIVEN HEALTH PLANS

AC = Allowable Charge	Anthem HealthKeepers Lumenos HSA 573 (POS – Open Access)	Optima Equity Vantage 3000/100% (POS – Open Access)
	In Network	**In Network**
Physical, Occupational and Other Therapy	Covered at 100% after deductible	Covered at 100% after deductible
Maternity	Covered at 100% after deductible	Covered at 100% after deductible
Hospital Services		
Ambulance Services	Covered at 100% after deductible	Covered at 100% after deductible
Outpatient Surgery	Covered at 100% after deductible	Covered at 100% after deductible
Inpatient Care	Covered at 100% after deductible	Covered at 100% after deductible
Emergency Room and Physician	Covered at 100% after deductible	Covered at 100% after deductible
Urgent Care Center	Covered at 100% after deductible	Covered at 100% after deductible
Mental Health and Substance Abuse Services		
Inpatient	Covered at 100% after deductible	Covered at 100% after deductible
Outpatient	Covered at 100% after deductible	Covered at 100% after deductible
Preventive		
Vision	$15 copay ; no deductible	$0 copay; no deductible
Well Baby	$0 copay then covered at 100%	$0 copay then covered at 100%
Annual Physical	$0 copay then covered at 100%	$0 copay then covered at 100%

CONSUMER DRIVEN HEALTH PLANS

AC = Allowable Charge	Anthem HealthKeepers Lumenos HSA 573 (POS – Open Access)	Optima Equity Vantage 3000/100% (POS – Open Access)
	In Network	**In Network**
Prescription Drug Benefits		
	Mandatory Generic	Mandatory Generic
Retail **30-day supply Anthem** **31-day supply Optima**	Preventive Drugs* No copy, no deductible Tier 1: Selected Generic: $15 copay Tier 2: Selected Brand and Other Generic: $40 copay Tier 3: Non-Selected Brand: $75 copay Tier 4 Specialty Drugs: 20% up to 200	Preventive Drugs* No copy, no deductible Tier 1: Selected Generic: $15 copay Tier 2: Selected Brand and Other Generic: $40 copay Tier 3: Non-Selected Brand: $75 copay Tier 4 Specialty Drugs: 20% up to $200
Mail Order **90-day supply** **(2.5 times retail copay)**	Preventive Drugs* No copy, no deductible Tier 1: Selected Generic: $38 copay Tier 2: Selected Brand and Other Generic: $100 copay Tier 3: Non-Selected Brand: $188 copay Tier 4: Specialty Drugs: 20% up to $400	Preventive Drugs* No copy, no deductible Tier 1: Selected Generic: $38 copay Tier 2: Selected Brand and Other Generic: $100 copay Tier 3: Non-Selected Brand: $188 copay Tier 4: Specialty Drugs: N/A
Retail 90 Pharmacy **(3 x retail copays)**	Preventive Drugs* No copy, no deductible Tier 1: Selected Generic: $45 copay Tier 2: Selected Brand and Other Generic: $120 copay Tier 3: Non-Selected Brand: $225 copay Tier 4: Not applicable	Not offered by Optima

***Per Preventive Drug Lists provided and maintained by Anthem and Optima**

Dental Options - This is a brief comparison. For more information and limits, consult the fee schedule, plan summary and/or evidence of coverage.

UCR = Usual, Customary and Reasonable Charge	DeltaCare DHMO	Delta Dental PPO Plus Premier Plan 1	Delta Dental PPO Plus Premier Plan 2
Type	Managed Care	Fee for Service	Fee for Service
Dentist Choice	From Panel	Any; Maximum benefit if participating PPO or Premier Network dentist	
Deductible per Contract Year	None	$25/person per patient $75/family per contract year Diagnostic & Preventive services exempt	$75/person per patient $225/family per contract year Diagnostic & Preventive services exempt
Maximum Benefit Amount per Contract Year	No limit	$1,000/person	**$1,250**/person (Diagnostic & Preventative Services do not count towards maximum per contract year)
Diagnostic & Preventive Services			
Oral Exam & Cleaning (2x/yr)	100%	100% UCR	100% UCR
X-rays (bitewings 1x/yr; full mouth 1x/3yrs)	100%	100% UCR	100% UCR
Sealants (age 16 & under)	See fee copay schedule	100% UCR	100% UCR
Basic Services			
Fillings	See fee copay schedule	90% PPO dentist after deductible 80% UCR Premier dentist after deductible Includes composite/white fillings	90% PPO dentist after deductible 80% UCR Premier dentist after deductible Includes composite/white fillings
Oral Surgery & Extractions	See fee copay schedule	90% PPO dentist after deductible 80% UCR Premier dentist after deductible	90% PPO dentist after deductible 80% UCR Premier dentist after deductible
Endodontics/ Periodontics	See fee copay schedule	90% PPO dentist after deductible 80% UCR Premier dentist after deductible	90% PPO dentist after deductible 80% UCR Premier dentist after deductible
Denture Repair/ Recementation	See fee copay schedule	90% PPO dentist after deductible 80% UCR Premier dentist after deductible	90% PPO dentist after deductible 80% UCR Premier dentist after deductible
Major Services			
Crowns	See fee copay schedule	Not Covered	60% PPO dentist after deductible 50% UCR Premier dentist after deductible
Prosthetic Coverage	See fee copay schedule	Not Covered	60% PPO dentist after deductible 50% UCR Premier dentist after deductible
Orthodontics (age 19 and under)	See fee copay schedule	Not Covered	50% UCR $1,000/lifetime maximum
Implants	Not Covered	Not Covered	60% PPO dentist after deductible 50% UCR Premier dentist after deductible